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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 09/18/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

1 Surgical Assistant (Physician Assistant), 1 Left Knee Arthroscopy with Anterior Cruciate Ligament Reconstruction using Hamstring Autograft and Medial Meniscus Debridement versus Repair

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female. On xxxxx, x-rays of her left tibia and fibula and knee were obtained showing no evidence of acute process or fracture or dislocation. On xxxxx, a MRI left knee revealed a tear of the posterior horn of the medial meniscus, and an intrasubstance tear of the anterior cruciate ligament with slight anterior drawer sign. There was pre-patella contusion or scarring and findings were stated be positive for abnormal patella mechanism. On 07/29/15, the patient was seen in physical therapy. On 08/20/15, the patient returned to clinic. She had subjective complaints of persistent instability as well as pain and she was not wearing her brace. She stated her knee shifted on her. It was noted that despite physical therapy she not she had not improved. On exam, she had 0-130 degrees of range of motion of the left knee without varus or valgus instability. Strength was 5/5. She had a grade 2+ Lachman with a soft endpoint and she had a grade 2+ anterior drawer. The MRI was reviewed with her. Recommendation was for surgery.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 08/03/15, a utilization review report noted the requested procedures were non-certified. Rationale was that the documentation submitted for review did not indicate that this patient had participated in previous physical therapy nor was it evidence that she had instability. The surgical procedures were not warranted, and the surgical assistant was not warranted.

On 08/13/15, a utilization review report noted the requested procedures were not supported as being medically necessary, as the patient had completed the initial physical therapy evaluation and was not shown to have failure of an adequate trial physical therapy. As the surgical intervention was not supported, the request for an assistant sir insistent in the form of a PA was not supported and the request was non-certified.

The submitted records indicate the patient has a MRI verified tear of the medial meniscus as well as an anterior cruciate ligament tear. The records indicate that as of 08/12/15, the patient had undergone three physical therapy visits although six had been authorized. On 08/18/15, the patient had undergone four physical therapy visits. Last physical therapy note submitted is that of 08/19/15, in which it was noted the patient had undergone five physical therapy visits.

The patient has positive Lachman's on exam, and a positive anterior drawer. The guidelines indicate that for anterior cruciate ligament reconstruction to be considered reasonable, there should be objective findings such as a positive Lachman's, and imaging studies should be positive for pathology. There should be documentation of conservative care, except in a case of an acute injury in the presence of a hemarthrosis, such as physical therapy or brace. The records indicate the patient is not wearing a brace although she been apparently been provided one. She has undergone five physical therapy visits to date, not indicative of a significant trial of physical therapy. As such, is the opinion of this reviewer that the request for one left knee arthroscopy with anterior cruciate ligament reconstruction using hamstring autograft and medial meniscus debridement versus repair is not medically necessary.

As the surgical intervention is not supported, it is the opinion of this reviewer that the request for surgical assistant, physician assistant, is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)